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No. OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1999

NME HOSPITALS, INC.
D/B/A LUTHERAN MEDICAL CENTER, *et al.*,
Petitioners,

v.

MISSOURI DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,
Respondent.

On Petition for Writ of Certiorari to the
Missouri Court of Appeals For the Western District

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Pursuant to State Regulation 13 C.S.R. 70-15.010(15), Missouri adopted a cap on the per diem payment it would pay Medicaid providers for inpatient psychiatric services ("Pysch Cap") they provided to Medicaid beneficiaries. This regulation was challenged in a separate action and found invalid and void on the basis that it violated federal Medicaid law, specifically the Boren Amendment. 42 U.S.C. § 1396a(13)(A) (repealed 1997). Those hospitals that first challenged the Pysch Cap were awarded the difference between what they were reimbursed with the Pysch Cap and what they should have received without it. These Petitioners subsequently sought, but were denied, this same relief. The questions presented here are:

1. Whether Petitioners are entitled to the difference between what they were reimbursed for psychiatric services under the invalid Psych Cap and what they would have received without the Psych Cap, in light of this Court's ruling in *James B. Beam Distilling Co. v. Georgia*, 501 U.S. 529 (1991), which held that where a new rule of law has been applied to the litigants in one case, the rule must be applied with respect to all other similarly situated litigants, and Medicaid appeal cases from other states.

2. Whether a state, by simply withdrawing or repealing a regulation which has been found void because it violates federal Medicaid law, can avoid paying Medicaid providers the difference between what they were paid under the invalid regulation and what they should have been paid.

PARTIES

The following, who appeared as Plaintiffs/Appellants in the court below, are Petitioners in this Court: NME Hospitals, Inc., d/b/a Lutheran Medical Center; Deaconess Health Services, Corp., d/b/a Deaconess Hospital; St. John's Regional Health Center; St. Louis University Hospital, d/b/a St. Louis University Hospital Medical Center; Southeast Missouri Hospital Assoc., d/b/a Southeast Missouri Hospital; Lucy Lee Hospital, Inc.; St. Luke's Northland Hospital Corp.; Deaconess Medical Center – West Campus; Psychiatric Healthcare Corp. of Missouri, n/k/a Paracelsus Healthcare Corporation, d/b/a Lakeland Regional Hospital; St. John's Regional Medical Center; BHCA of Kansas City, Inc., f/k/a Valuemark Behavioral Healthcare of Kansas City, d/b/a North Hills Hospital, n/k/a Hallmark Youthcare – Kansas City, Inc. ("Petitioners" or "Hospitals").

The Missouri Department of Social Services, Division of Medical Services ("DMS" or "State") who appeared as Defendant/Respondent in the court below is named as Respondent in this Court.

Rule 29.6 List

NME Hospitals, Inc., d/b/a Lutheran Medical Center: Parent company – Tenet HealthSystem DI, Inc.

Deaconess Health Services Corp., d/b/a Deaconess Hospital: Member of Deaconess Incarnate Word Health System, which is controlled by The Deaconess Foundation and Incarnate Word Health System

St. John's Regional Health Center: Parent company – St. John's Health System, Inc.

St. Louis University Hospital, d/b/a St. Louis University Hospital Medical Center: There is no parent or publicly held company owning 10% or more of the entity.

Southeast Missouri Hospital Assoc., d/b/a Southeast Missouri Hospital: There is no parent or publicly held company owning 10% or more of the entity.

Lucy Lee Hospital, Inc.: Parent company - Tenet HealthSystem Medical, Inc.

St. Luke's Northland Hospital Corp.: Parent company – Saint Luke's Hospital of Kansas City

Deaconess Medical Center – West Campus: Member of Deaconess Incarnate Word Health System, which is controlled by The Deaconess Foundation and Incarnate Word Health System

Psychiatric Healthcare Corp. of Missouri, n/k/a Paracelsus Healthcare Corporation, d/b/a Lakeland Regional Hospital: Entities owning more than 10% of entity – Park-Hospital GmbH

St. John's Regional Medical Center: Parent company – Catholic Health Initiatives

BHCA of Kansas City, Inc., f/k/a Valuemark Behavioral Healthcare of Kansas City, d/b/a North Hills Hospital, n/k/a Hallmark Youthcare – Kansas City, Inc.: Parent company – Hallmark Systems, Inc.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES	ii
RULE 29.6 LIST	ii
TABLE OF AUTHORITIES	vi
OPINIONS BELOW	1
JURISDICTIONAL STATEMENT	1
STATUTORY PROVISION INVOLVED	1
STATEMENT OF THE CASE	2
Procedural Background	4
Decision of the Court of Appeals	7
How the Federal Questions were Presented	7
REASONS FOR GRANTING THE WRIT	9
I. THE MISSOURI COURT OF APPEALS' RULING, WHICH HAS THE EFFECT OF TREATING SIMILARLY SITUATED ENTITIES DIFFERENTLY, IS SO PLAINLY WRONG UNDER THIS COURT'S PRECEDENT AND MEDICAID APPEAL CASES FROM OTHER STATES AS TO WARRANT SUMMARY REVERSAL	11
II. A STATE SHOULD NOT BE PERMITTED TO AVOID LIABILITY AND FEDERAL REMEDY AND RETROACTIVITY PRINCIPLES BY SIMPLY WITHDRAWING A	

REGULATION WHICH HAS ALREADY BEEN DECLARED INVALID AND VOID BECAUSE IT VIOLATES FEDERAL MEDICAID LAW 16

CONCLUSION 18

TABLE OF AUTHORITIES

CASES Page

American Trucking Assn's, Inc. v. Sheiner, 483 U.S. 266 (1987) 12

Americare Properties, Inc. v. Whiteman, 891 P.2d 336 (Kan. 1995) 15

Avon Nursing Home v. Axelrod, 639 N.E.2d 1124 (N.Y. 1994) 14, 15

Bacchus Imports, Ltd. v. Dias, 468 U.S. 263 (1984) 11, 12

Dept. of Soc. Servs. v. Alexian Bros. of St. Louis, Inc., 930 S.W.2d 439 (Mo. App. W.D. 1996) 4, 5, 6, 12, 14, 16

Dept. of Soc. Servs. v. Great Plains Hosp., 930 S.W.2d 429 (Mo. App. W.D. 1996) 3, 4, 5, 6, 7, 8, 11, 12, 13, 14, 16

Dept. of Soc. Servs. v. Trinity Lutheran Hosp., 930 S.W.2d 426 (Mo. App. W.D. 1996) 4, 5, 6, 12, 14, 16

Desist v. United States, 394 U.S. 244 (1969) 13

Harper v. Virginia Dept. of Taxation, 509 U.S. 86 (1993) 14

James B. Beam Distilling Co. v. Georgia, 501 U.S. 529 (1991) 9, 10, 11, 12, 13, 14, 15, 17

New England Mem'l Hosp. v. Rate Setting Comm'n, 475 N.E.2d 740 (Mass. 1985)..... 15

Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2nd Cir. 1991) 14, 15

Psychcare Management v. Dept. of Soc. Servs., 980 S.W.2d 311 (Mo. banc 1998)..... 17

Volk v. Dept. of Human Resources, 799 P.2d 658 (Or. 1990) 15

FEDERAL STATUTES

28 U.S.C. § 1257 1

42 U.S.C. § 1396 et seq. (1992)..... 2

42 U.S.C. § 1396a(13)(A) (repealed 1997)..... 1, 2, 3

42 U.S.C. § 1396a(13)(A) (1997) 3

42 U.S.C. § 1396a(37) (1977) 5

OTHER AUTHORITIES

42 C.F.R. § 447.253(e)..... 5

Mo. Rev. Stat. § 208.156 (1994) 6

Mo. Rev. Stat. § 208.156.4 (1994) .. 6, 7, 8, 10, 11, 16, 17

Mo. Rev. Stat. § 621.055 (1984) 5

13 C.S.R. 70-15.010..... 4

13 C.S.R. 70-15.010(15) 3

PETITION FOR WRIT OF CERTIORARI

Petitioners respectfully request that a writ of certiorari be issued to review the ruling of the Missouri Court of Appeals for the Western District in this case.

OPINIONS BELOW

The opinion of the Missouri Court of Appeals for the Western District is reported at 11 S.W.3d 776 and is reproduced in the Appendix to this Petition for Certiorari ("Pet. App."), beginning at page A-1. The unpublished order of the Administrative Hearing Commission, which found that Petitioners were entitled to Medicaid reimbursement after the invalidation of the Psych Cap, appears at Pet. App. A-11. The opinion of the Circuit Court of Cole County (Pet. App. *infra*, A-28) is unreported.

JURISDICTIONAL STATEMENT

The Missouri Court of Appeals for the Western District entered its opinion and judgment on December 28, 1999. On February 1, 2000, the Court of Appeals denied the Hospitals' timely Motion for Rehearing and Application for Transfer. On March 21, 2000, the Missouri Supreme Court denied the Application for Transfer filed with that court. This Court has jurisdiction pursuant to 28 U.S.C. § 1257.

STATUTORY PROVISION INVOLVED

The Boren Amendment, 42 U.S.C. § 1396a(13)(A) (repealed 1997), which was in effect at all times pertinent hereto, required a state Medicaid plan to:

> Provide . . . for payment . . . of the hospital services . . . provided under the plan through the use of rates

> . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations, and quality and safety standards . . . .

42 U.S.C. § 1396a(13)(A) (repealed 1997).

STATEMENT OF THE CASE

The Petitioners in this case are Missouri healthcare providers that provided inpatient psychiatric services to Medicaid beneficiaries. They seek to be reimbursed for these services at rates determined to be reasonable and adequate under the last validly promulgated State Medicaid Plan rather than at a fixed rate that was enacted in violation of federal Medicaid law.

The Medicaid Act, 42 U.S.C. § 1396 *et seq.* (1992), authorizes federal grants to help states provide medical assistance to certain low income individuals. Participation in the program is voluntary. If, however, a state chooses to participate in the program, then, in exchange for federal funding, it must comply with certain federal regulations. In order to receive federal Medicaid funds a state is required to submit a state Medicaid assistance plan to the Health Care Financing Administration, which is the agency within the federal Department of Health and Human Services designated by Congress to administer the Medicaid program at the federal level. That plan is to include the methodology the state will use to reimburse healthcare providers for the services they provide Medicaid beneficiaries. Under the 1981 Boren Amendment to the Medicaid Act, the plan had to

include the state's "findings" and "assurances" that its reimbursement rates were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" and that the plan complied with applicable federal laws and regulations. 42 U.S.C. § 1396a(13)(A) (repealed 1997).[1]

Prior to January 1, 1990, Missouri healthcare providers received per diem reimbursement based on their actual cost of care. This per diem rate was part of the State Medicaid Plan for which the necessary "findings" and "assurances" had been made ("Plan Rate"). In 1990, DMS, the state agency that administers the Missouri Medicaid program, enacted 13 C.S.R. 70-15.010(15), which placed a cap on the per diem reimbursement for inpatient psychiatric services. In every case, the Psych Cap was lower than the Plan Rate that the Petitioners were receiving prior to the adoption of the Psych Cap.

In *Dept. of Soc. Services v. Great Plains Hosp.*, the Missouri Court of Appeals determined that the DMS violated federal Medicaid law, more specifically the "findings" requirement of the Boren Amendment, when it enacted the Psych Cap. *Dept. of Soc. Services v. Great Plains Hosp.*, 930 S.W.2d 429, 437 (Mo. App. W.D. 1996). The court found the Psych Cap invalid and void and held that the hospital in *Great Plains* should recover reimbursement lost because of the invalid rule. *Id.* at. 437-38. The court held that the hospital "was entitled to be reimbursed pursuant to the previous

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[1] The Balanced Budget Act of 1997 repealed the Boren Amendment's requirement that a state must "find" and make "assurances" that the rates are "reasonable and adequate." 42 U.S.C. § 1396a(13)(A) (1997). Petitioners' cause of action, however, is for damages suffered prior to the repeal of the Boren Amendment.

unamended plan until such time as that plan [was] changed according to the applicable procedures." This same retroactive relief, i.e. the difference between what a hospital should have received for inpatient psychiatric services without the Psych Cap and what the hospital received with the Psych Cap, was subsequently provided to two other Missouri hospitals that had suffered similar damages as a result of the application of the invalid regulation and had sued to recover their losses. *See Dept. of Soc. Servs. v. Trinity Lutheran Hosp.*, 930 S.W.2d 426, 429 (Mo. App. W.D. 1996); *Dept. of Soc. Servs. v. Alexian Bros. of St. Louis, Inc.*, 930 S.W.2d 439, 441 (Mo. App. W.D. 1996).

After the Psych Cap was declared void in *Great Plains*, and after the decision reached in *Great Plains* was applied to the hospitals in *Trinity Lutheran* and *Alexian Brothers*, the Pysch Cap was temporarily withdrawn by the State through an emergency regulation filed on September 13, 1996. (L.F., Vol. I, pp. 141-42). The emergency amendment, which was adopted without prior public notice, became effective on October 1, 1996 and by its own terms expired on March 29, 1997. *Id.* A rule permanently withdrawing the Psych Cap regulation took effect on April 30, 1997. (13 C.S.R. 70-15.010) (L.F., Vol. I, p. 145).

Procedural Background

Petitioners suffered damages identical to the type of damage suffered by the hospitals in *Great Plains*, *Trinity Lutheran*, and *Alexian Brothers*. Consequently, shortly after the *Great Plains* decision became final, these Hospitals sought to recover Medicaid reimbursement that they would have received but for the invalid Psych Cap regulation. In other words, they sought the

same relief afforded the hospitals in *Great Plains*, *Trinity Lutheran*, and *Alexian Brothers*. Petitioners sent letters to the Director of DMS claiming that they were entitled to Medicaid reimbursement plus interest for the difference between the Plan Rate and the Psych Cap rate. (L.F. 10-11). These claims were filed after the Psych Cap was temporarily withdrawn, but before it was permanently withdrawn. The State denied these claims. (L.F. 12-13).

Pursuant to Section 1396a(37) of the Medicaid Act, state Medicaid plans are to provide for claim review in order "to ensure the proper and efficient payment of claims and management of the program." 42 U.S.C. § 1396a(37). The federal regulations require an appeal process:

> (e) Provider Appeals. The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 C.F.R. § 447.253(e). In Missouri, this appeal process is conferred by Section 621.055, Mo. Rev. Stat., which provides in pertinent part:

> Any person authorized under section 208.153, RSMo, to provide services for which benefit payments are authorized under section 208.152, RSMo, may seek review by the administrative hearing commission of any of the actions of the department of social services specified in subsection 2, 3, or 4 of section 208.156, RSMo.

Section 208.156, Mo. Rev. Stat. (1994)[2], grants healthcare providers, such as Petitioners, the right to seek review of the State's actions. Section 208.156.4 grants a hearing before the Administrative Hearing Commission ("AHC") to any Medicaid provider "who is aggrieved by any rule or regulation promulgated by the department of social services." § 208.156.4, Mo. Rev. Stat. Pursuant to Section 208.156 Petitioners filed Complaints with the AHC claiming they were aggrieved as a result of the application of the invalid Psych Cap regulation. (L.F. 3-8). The AHC, after consolidating Petitioners' claims, held that it had jurisdiction pursuant to Section 208.156.4. It then granted summary determination in favor of Petitioners and ordered the same relief for Petitioners that was previously awarded in *Great Plains*, *Trinity Lutheran*, and *Alexian Brothers* (i.e. the State was ordered to reimburse the Hospitals the amount that the State had withheld under the invalid Psych Cap). (L.F. 171-182).

DMS sought review of this decision in the Circuit Court of Cole County. (L.F. 838-860). The Hospitals filed Cross-Petitions for Judicial Review alleging that the AHC failed to award appropriate interest. (L.F. 861-877). The cases were consolidated for review and the Circuit Court of Cole County reversed the AHC's decision, holding that the AHC did not have subject matter jurisdiction because the Psych Cap regulation was not in effect at the time that the Hospitals filed their claims. (L.F. 878-883) (Pet. App. A-31-32).

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[2] Unless otherwise indicated, all cites are to Section 208.156, Mo. Rev. Stat. (1994).

Decision of the Court of Appeals

The Court of Appeals affirmed the judgment of the Circuit Court, holding that once the Psych Cap rule was withdrawn the AHC no longer had jurisdiction to hear claims brought for damages arising from the prior application of the invalid regulation. (Pet. App. A-9-10). It further held that had Petitioners "brought complaints challenging the validity of the Psych Cap regulation during the time when the regulation was in effect, as did the hospitals in *Great Plains* and the two companion cases, the AHC would have had jurisdiction over the complaints pursuant to Section 208.156.4." (Pet. App. A-9).

The Hospitals subsequently filed a Motion for Rehearing and an Application for Transfer with the Missouri Court of Appeals. On February 1, 2000, the Court of Appeals denied the Motion for Rehearing and Application for Transfer. The Hospitals then filed their Application for Transfer with the Supreme Court of Missouri. On March 21, 2000, the Missouri Supreme Court denied the Hospitals' Application.

How the Federal Questions were Presented

This case involves the rights of Medicaid providers and the obligations of those states that choose to participate in the federal Medicaid program. More specifically, this case involves the rights of Medicaid providers to be reimbursed at rates established under a validly promulgated Medicaid plan and whether a state can ignore those rights and avoid its obligations by simply withdrawing a regulation that has already been declared invalid and void under federal Medicaid law. These federal Medicaid issues and concerns are intri-

cately intertwined with the facts of this case, are central to this entire lawsuit, and were raised below.

For example, in their Motion for Rehearing, the Hospitals argued, among other things, that the AHC's jurisdiction under Section 208.156.4 should not be tied to whether a regulation is currently in existence because that has no bearing on whether the entity is actually aggrieved by the rule and could promote manipulation of the Medicaid system. In their Application for Transfer, filed in the Missouri Court of Appeals, the Hospitals argued that the court's interpretation of Section 208.156.4 prevented damage claims of some while allowing others with identical type claims to recover simply because they were the first to raise the issue. The Hospitals further argued that the Court of Appeals' interpretation of the statute eliminated the State's responsibility and accountability for enacting invalid Medicaid rules. In their Application for Transfer filed in the Supreme Court of Missouri, Petitioners argued that the ability of the State to dispose of claims of Medicaid providers simply by adopting regulations withdrawing invalid rules affects the whole Medicaid program; sanctions the State's unlawful violation of Medicaid laws; results in the State facing minimal risk in enacting and carrying out invalid Medicaid rules; and would give states the opportunity to manipulate the Medicaid system at will.

Not only were these federal issues raised below, but this case was brought and decided in the wake of *Great Plains,* which held that the Psych Cap was invalid and void because it violated federal Medicaid law, i.e. the Boren Amendment. Petitioners sought to have this decision, which is based in federal law, applied to them.

In doing so, Petitioners relied on this Court's decision in *James B. Beam Distilling Co. v. Georgia*, 501 U.S. 529 (1991). *Beam,* and the principles of retroactivity and remedy set forth in that case, were raised in the Hospitals' brief filed in the Missouri Court of Appeals, in the Motion for Rehearing, and in the Applications for Transfer filed in both the Court of Appeals and the Supreme Court of Missouri.

Federal Medicaid law, facts, issues, and concerns are so intertwined and implicated in this case that state law does not independently and adequately support the judgment. In addition, the decision of the court below conflicts with the principles of retroactivity and remedy set forth in this Court's decision in *Beam*. Both items were raised below. Consequently, this Supreme Court has authority to review the state court decision.

REASONS FOR GRANTING THE WRIT

This Petition for writ of certiorari should be granted because a state should not be allowed to avoid accountability for its violation of federal Medicaid law by simply repealing what has already been found to be a void regulation. To tie the jurisdiction of the AHC and the remedy of other providers injured by the same void act to what should be a meaningless act, i.e. the withdrawal of a void regulation, violates the principles underlying this Court's decision in *Beam* and renders all Medicaid providers susceptible to improper and unfair manipulation of the Medicaid reimbursement process.

In *Beam*, this Court clearly recognized that where a new rule of law has been applied to the litigants in one case, the rule must be applied with respect to all other similarly situated litigants who are not barred by proce-

dural requirements or res judicata. 501 U.S. at 544. This Court further recognized that retroactive application of a decision should not be limited to only those who had a challenge pending at the time of the decision. *Id.* at 542-43. For as this Court correctly observed, "distinguishing between those with cases pending and those without would only serve to encourage the filing of replicative suits when this or any other appellate court created the possibility of a new rule by taking a case for review." *Id.*

The Court of Appeals' interpretation of Petitioners' Medicaid appeal rights under Section 208.156.4, Mo. Rev. Stat., extinguishes the damage claims of some while allowing others with identical type claims to recover simply because they were the first to race to the court house. This interpretation does just what this Court in *Beam* was trying to prevent. 501 U.S. 529, 541-43. Moreover, the simple repeal or withdrawal of an already invalid and void regulation does not eliminate the damages incurred by Missouri providers as a result of the State's violation of federal Medicaid law for over six years. By the same token, the repeal or withdrawal of an invalid and void regulation should not cut off retroactive relief that one would otherwise be entitled to or divest the AHC of subject matter jurisdiction. If it does, then the Medicaid system is susceptible to improper manipulation.

The Court should issue a writ of certiorari to correct the decision of the court below and to provide needed guidance on these important issues.

I. THE MISSOURI COURT OF APPEALS' RULING WHICH HAS THE EFFECT OF TREATING SIMILARLY SITUATED ENTITIES DIFFERENTLY IS SO PLAINLY WRONG UNDER THIS COURT'S PRECEDENT AND MEDICAID APPEAL CASES FROM OTHER STATES AS TO WARRANT SUMMARY REVERSAL.

On October 22, 1996, the Missouri Supreme Court denied the Application for Transfer that was filed in *Great Plains*. Seven days later, on October 29, 1996, Petitioners began filing their claims. Petitioners, relying on principles set forth in *Beam*, waited until the decision in *Great Plains* was final before filing their lawsuits. They did this in order to avoid separate and repeated litigation of the same issue. Now they are being punished for having done so. The decision reached in the court below is so clearly wrong under this Court's precedent and Medicaid appeal cases from other states as to warrant summary reversal.

In *Beam*, Georgia law imposed an excise tax on imported liquor at a rate double that imposed on liquor manufactured from Georgia-grown products. In 1984, the Court held that a similar Hawaiian law violated the Commerce Clause. *Bacchus Imports, Ltd. v. Dias*, 468 U.S. 263, 276 (1984). After the *Bacchus* opinion was announced by this Court, a Kentucky manufacturer brought suit in Georgia State court seeking a retroactive refund of taxes it paid under Georgia's law for 1982, 1983, and 1984. The Georgia court relying on *Bacchus* declared the statute unconstitutional but refused to apply its ruling retroactively. The Georgia Supreme Court affirmed the decision and applied the finding on a prospective-only basis in that it declined to declare the

state's application of the statute unconstitutional for the years in question. *Beam*, 501 U.S. at 533.

This Court reversed the Georgia Supreme Court's decision and held that once a court has applied a rule of law to the litigants in one case, it must do so with respect to all others not barred by procedural requirements or res judicata. *Beam*, 501 U.S. at 533-34. This Court held that *Bacchus* applied retroactively to claims arising on similar facts antedating the *Bacchus* decision as well as later cases. *Beam*, 501 U.S. at 532. "The question presented is whether our ruling in *Bacchus* [full citation omitted] should apply retroactively to claims arising on facts antedating that decision. We hold that application of the rule in that case requires its application retroactively in later cases." *Id.*

The *Beam* case is controlling on the issue of retroactive application of the law. Even though this case involves a regulation, which was found to violate federal Medicaid law, and not constitutional law, the doctrine of retroactivity as discussed in the *Beam* case is "overwhelmingly the norm" in civil matters. *Beam*, 501 U.S. at 535.

None of the decisions in *Great Plains*, *Alexian Brothers*, or *Trinity Lutheran* remanded the cases to determine whether or not the law should be applied retroactively or prospectively. *See American Trucking Assn's, Inc. v. Sheiner*, 483 U.S. 266, 297-98 (1987) (showing the Court's ability to reserve the question of retroactivity). Those three cases all held that the hospitals were entitled to be reimbursed the difference between the amounts that they received with the Psych Cap and the amounts that they should have received without it. Since the *Great Plains* court provided a retroactive

remedy to the litigants before it, the same remedy should be applied to all other litigants. *Beam*, 501 U.S. at 538-40. The ruling in *Great Plains* must be applied to all other hospitals who make the same claim for reimbursement who are not barred by the statute of limitations or res judicata. *Id.* at 544. There exists no procedural bar to Petitioners raising these claims.

The court below held that *Great Plains* does not apply to Petitioners because the Psych Cap regulation was no longer in effect when they filed their claims. The Court of Appeals concluded that because the Psych Cap rule was not in effect at the time Petitioners' claims were filed, because it had been temporarily repealed by an emergency rule on September 13, 1996, Petitioners were not "presently aggrieved" and therefore the AHC lacked jurisdiction over their claims. Essentially the Court of Appeals held that except for *Great Plains* and its companion cases, *Great Plains* must be given prospective effect only and that no other hospitals may be reimbursed for their damages resulting from the invalid Psych Cap.

If allowed to stand, the Court of Appeals' decision would preclude Petitioners from suit because they did not beat the hospital in *Great Plains* to court. This Court, in rejecting such a result, has noted that selective prospectivity breaches the principle that "litigants in similar situations should be treated the same." *Beam*, 501 U.S. at 537-38. This Court has further recognized that it is a departure from basic judicial tradition when "we simply pick and choose from among similarly situated defendants those who alone will receive the benefit of a 'new' rule of constitutional law." *Id.* (quoting *Desist v. United States*, 394 U.S. 244, 258-59 (1969) (Harlan, J., dissenting)).

Moreover, as this Court has recognized, the fact that Petitioners did not have a claim pending at the time that the Psych Cap was found invalid and void does not eliminate their right to proper reimbursement for Medicaid services.

> We might, of course, limit retroactive application to those who at least tried to fight their own battles by litigating before victory was certain. To this possibility, ***it is enough to say that distinguishing between those with cases pending and those without would only serve to encourage the filing of replicative suits when this or any other appellate court created the possibility of a new rule by taking a case for review.***

Beam, 501 U.S. at 542-43 (emphasis added).

The application of the rule announced in *Great Plains* to Petitioners is governed by the retroactivity principles set forth in *Beam*. *See Harper v. Virginia Dept. of Taxation*, 509 U.S. 86 (1993) ("Whatever freedom state courts may enjoy to limit the retroactive operation of their own interpretations of state law . . . cannot extend to their interpretations of federal law."). Pursuant to those principles, Petitioners are entitled to the same relief that the hospitals in *Great Plains*, *Trinity Lutheran*, and *Alexian Brothers* received.

Applying the *Great Plains* decision retroactively is consistent with Medicaid appeal cases from other states as well. In the case of *In re Avon Nursing Home v. Axelrod*, 639 N.E.2d 1124, 1127 (N.Y. 1994), following invalidation of the state's Medicaid reimbursement methodology by the Second Circuit Court of Appeals on Boren Amendment grounds in *Pinnacle Nursing Home*

v. Axelrod, 928 F.2d 1306 (2nd Cir. 1991), a group of nursing homes commenced an action to recover underpayments due to the application of the unlawful regulation to them in prior years. New York's highest state court affirmed the lower court's decision and granted retroactive relief for the period of 1987-1991 under the previously existing rate structure and without regard to the invalid regulation. The court stated, "[P]etitioners are entitled to have their rates for the years in dispute recalculated and to be reimbursed for any amounts owed them by reason of that recalculation." *In re Avon Nursing Home*, 639 N.E.2d at 1127. Other cases in which Medicaid reimbursement methodology has been invalidated have also awarded relief to the provider based upon the previous unamended plan. *See Volk v. Dept. of Human Resources*, 799 P.2d 658, 664 (Or. 1990) ("We agree with plaintiffs that, on invalidation of the plan amendments, reimbursement must be made pursuant to the previous unamended plan."); *Americare Properties, Inc. v. Whiteman*, 891 P.2d 336, 349 (Kan. 1995) (affirming trial court decision invalidating Medicaid Plan and requiring reimbursement under prior plan); *New England Mem'l Hosp. v. Rate Setting Comm'n*, 475 N.E.2d 740, 745 (Mass. 1985) ("Where no effective new rate has been established, the old rate remains in effect.").

In light of this Court's decision in *Beam* and Medicaid appeal cases from other states, the Missouri Court of Appeals erred in not allowing Petitioners the relief which was afforded other similarly situated hospitals.

II. A STATE SHOULD NOT BE PERMITTED TO AVOID LIABILITY AND FEDERAL REMEDY AND RETROACTIVITY PRINCIPLES BY SIMPLY WITHDRAWING A REGULATION WHICH HAS ALREADY BEEN DECLARED INVALID AND VOID BECAUSE IT VIOLATES FEDERAL MEDICAID LAW.

Despite the fact that Petitioners have suffered identical damages to those suffered by the hospitals in *Great Plains*, *Trinity Lutheran*, and *Alexian Brothers*, the Missouri Court of Appeals denied Petitioners the same relief because the State took the meaningless act of withdrawing an administrative rule already declared invalid and void under federal Medicaid law. Had this act not been taken, then according to the court below, the AHC would have had jurisdiction to hear the Hospitals' claims because Petitioners would then have been Medicaid providers *presently* aggrieved by an *existing* rule or regulation promulgated by the DMS. (Pet. App. A-8).[3]

The withdrawal of a Medicaid regulation, after it has been applied to a Medicaid provider's detriment, should not be the determining factor in deciding whether that provider is aggrieved; should not divest the AHC of jurisdiction over Medicaid claims arising from the impo-

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[3] In fact, the words *presently* and *existing* do not appear either explicitly or by implication in Section 208.156.4, Mo. Rev. Stat.

> Any person . . . who ***is aggrieved by any rule or regulation*** promulgated by the department of social services or any division therein shall be entitled to a hearing before the administrative hearing commission . . .

§ 208.156.4, Mo. Rev. Stat. (emphasis added)

sition of the rule or regulation; should not allow a state to avoid liability for violating federal Medicaid law; should not extinguish Medicaid provider appeal rights; and should not defeat the retroactivity principles set forth in *Beam*. This is particularly true, where as here, the withdrawn Medicaid regulation has already been declared invalid and void. The withdrawal of a rule that has been declared invalid and void is, or at least should be, a meaningless act. *See Psychcare Management v. Dept. of Soc. Servs.*, 980 S.W.2d 311, 313 (Mo. banc 1998). Since the Psych Cap never had the force and effect of law, it was a nullity. Thus, its withdrawal after being judicially declared invalid was meaningless and should not be a determining factor in this case.

The Missouri Court of Appeals' interpretation of Section 208.156.4, Mo. Rev. Stat., is wrong because it sanctions the State's unlawful violation of the Boren Amendment, results in the State facing minimal risk in enacting and carrying out invalid Medicaid rules in the future, and extinguishes Medicaid provider appeal rights. The Court of Appeals' decision states that the AHC will have jurisdiction only in cases where a person is *presently* injured by an *existing* rule. Thus, under the Court of Appeals' interpretation, the State is now free to enact a questionable Medicaid rule and if a challenge is upheld, the State can quickly withdraw it while it is on appeal, thereby avoiding liability to all other providers for violation of federal Medicaid law and extinguishing their appeal rights. If the challenge is denied, then the State can re-enact the rule by emergency amendment with a retroactive effective date. Medicaid providers and beneficiaries should not be subject to such arbitrary conduct by states.

A state should not be allowed to avoid paying Medicaid providers the difference between what they were paid under an invalid regulation and what they should have been paid simply because the state withdrew a regulation which had already been declared invalid and void under federal Medicaid law. The decision of the court below eliminates the State's responsibility and accountability for enacting invalid Medicaid rules and renders the entire Medicaid system susceptible to improper and unfair manipulation.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

MISSOURI COURT OF APPEALS
WESTERN DISTRICT

MISSOURI DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,
Respondent,
vs.
NME HOSPITAL, INC.
d/b/a Lutheran Medical Center, et al.,
Appellants.

WD56901(Consolidated with WD56902 through
WD56911 and WD57007)

Opinion Filed: December 28, 1999

APPEAL FROM THE CIRCUIT COURT
OF COLE COUNTY
The Honorable Thomas Joseph Brown III, Judge

Before Spinden, P.J., Lowenstein, J. and Ulrich, J.

NME Hospital, Inc. d/b/a Lutheran Medical Center and eleven other hospitals[1] (Hospitals) appeal the judg-

[1]Deaconess Health Services Corporation d/b/a Deaconess Hospital; St. John's Regional Health Center; St. Louis University d/b/a St. Louis University Medical Center; Southeast Missouri Hospital Association d/b/a Southeast Missouri Hospital; Lucy Lee Hospital; St. Luke's Northland Hospital; Deaconess Medical Center-West Campus; Psychiatric Healthcare Corporation of Missouri d/b/a Lakeland Regional Hospital; St. John's Regional Medical Center; BHCA of Kansas City, Inc. d/b/a ValueMark Behavioral Healthcare of Kansas City d/b/a North Hills Hospital; Missouri Healthcare System, L.P.

ment of the circuit court reversing the order of the Administrative Hearing Commission (AHC) finding that Hospitals were entitled to Medicaid reimbursements of over $30,000,000 after the invalidation of a cap imposed by the Department of Social Services, Division of Medical Services (DMS) on reimbursement rates for certain inpatient psychiatric services. In reversing the AHC's order, the circuit court found that the AHC lacked subject matter jurisdiction to hear Hospitals' complaints. The judgment of the circuit court is affirmed.

DMS is the state agency responsible for administering the Medicaid program in the State of Missouri. Hospitals owned and operated duly licensed and accredited hospitals that provided inpatient psychiatric services for which reimbursement was provided under Missouri's Medicaid plan. Prior to January 1, 1990, health care providers within the Missouri Medicaid program received reimbursements from DMS for such services based on a per diem rate. In 1990, DMS adopted a regulation, 13 CSR 70-15.010(15), which placed a ceiling or cap on the per diem reimbursement rates for certain inpatient psychiatric services.

In 1992 and 1993, three hospitals, in three separate cases, challenged the validity of the psychiatric reimbursement cap. This court, in ***Missouri Dep't of Soc. Servs., Div. of Medical Servs. v. Great Plains Hosp., Inc.*, 930 S.W.2d 429, 437 (Mo. App. W.D. 1996)**, found that the cap was invalid based on DMS's failure to meet the procedural requirements of the Boren Amendment[2]

[2]The Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A)(1992), requires a state to establish a scheme for reimbursing health care providers for the medical services they provide to Medicaid patients. ***Great Plains*, 930 S.W.2d at 431 (citing *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 499-502 (1990)).**

in placing the cap on per diem psychiatric reimbursements. The court then found that the hospital was entitled to be reimbursed pursuant to the last validly enacted Medicaid payment plan.[3] ***Id.* at 438**. Based on the holding in ***Great Plains***, DMS withdrew the invalid regulation on October 1, 1996.

Beginning on October 29, 1996, Hospitals filed claims with DMS demanding payment for the difference between the amounts Hospitals would have received without the cap and the amount they actually received for inpatient psychiatric services provided from 1990 through 1995, plus interest. These claims were denied by DMS. Hospitals also filed their complaints in the instant action before the AHC beginning on October 29, 1996, asserting entitlement to additional reimbursements from DMS based on the ***Great Plains*** decision. Thereafter, Hospitals filed motions for summary determination claiming that no factual, only legal, disputes existed. DMS filed its cross motions for summary determination agreeing that the cases involved only legal issues and arguing that Hospitals were not entitled to additional reimbursements under ***Great Plains*** because the AHC lacked subject matter jurisdiction to hear the complaints and Hospitals' complaints were barred by the doctrine of sovereign immunity and the statute of limitations.

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[3]The two companion cases, ***Missouri Dep't of Soc. Servs., Div. of Medical Servs. v. Trinity Lutheran Hosp.*, 930 S.W.2d 426, 429 (Mo. App. W.D. 1996)**, and ***Missouri Dep't of Soc. Servs., Div. of Medical Servs. v. Alexian Bros. of St. Louis, Inc.*, 930 S.W.2d 439, 441 (Mo. App. W.D. 1996)**, were decided the same day as ***Great Plains*** and also held that the hospitals were entitled to be reimbursed at the standard per diem rate based on the invalid cap.

The AHC issued decisions in favor of Hospitals on May 12, 1998, and thereafter. Although the AHC found that it did not have subject matter jurisdiction over Hospitals' claims under section 208.156.2[4], it found that jurisdiction was conferred under section 208.156.4. The AHC also found that DMS waived its sovereign immunity and that no statute of limitations applied to limit recovery. It concluded that under the decision in ***Great Plains*** and the two companion cases, Hospitals were entitled to reimbursements of over $30,000,000 withheld by imposition of the invalid cap from 1990 through 1995.

DMS filed its petitions for judicial review on June 4, 1998, in the circuit court. Hospitals filed cross petitions for judicial review alleging that the AHC failed to grant interest on the liquidated amount for the 13 month period during which Hospitals' motions for summary determination were under consideration. The cases were consolidated, and the circuit court reversed the AHC decisions finding that the AHC lacked subject matter jurisdiction to hear Hospitals' complaints. This appeal followed.

In an administrative review case, an appellate court will review the decision of the AHC and not the judgment of the circuit court. ***Psychcare Management, Inc. v. Department of Soc. Servs., Div. of Medical Servs.*, 980 S.W.2d 311, 312 (Mo. banc 1998)**. An appellate court is generally limited to determining whether the AHC's decision is supported by substantial and competent evidence upon the whole record; whether

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[4]All statutory references are to RSMo 1994 unless otherwise indicated.

the decision is arbitrary, capricious, or unreasonable; or whether the AHC abused its discretion. ***Id.*** The court may not determine the weight of the evidence or substitute its discretion for that of the administrative body. ***Id.*** Questions of law, however, are matters for the independent judgment of the court. ***Id.***

The issue of the AHC's subject matter jurisdiction in this case is dispositive, and the other issues raised are not addressed. Hospitals claim that the AHC had subject matter jurisdiction to hear and decide the complaints based on sections 208.156.2 and 208.156.4. The AHC is a creature of statute and "has only such jurisdiction or authority as may be granted by the legislature." ***Livingston Manor, Inc. v. Department of Soc. Servs., Div. of Family Servs.*, 809 S.W.2d 153, 156 (Mo. App. W.D. 1991)**. If the AHC lacks statutory power to consider a matter, it is without subject matter jurisdiction. ***Id.*** The AHC's jurisdiction in Medicaid service provider cases is conferred by section 621.055, which provides in pertinent part:

> Any person authorized under section 208.153, RSMo, to provide services for which benefit payments are authorized under section 208.152, RSMo, may seek review by the administrative hearing commission of any of the actions of the department of social services specified in subsection 2, 3, or 4 of section 208.156, RSMo.

§ 621.055.1. Thus, if DMS's actions in this case fell within the purview of subsections 2, 3, or 4 of section 208.156, the AHC had jurisdiction to entertain Hospitals' complaints. ***State ex rel. Oakwood Manor Nursing Ctr. v. Stangler*, 809 S.W.2d 90, 92 (Mo. App.**

W.D. 1991). Section 208.156 provides, in pertinent part:

> 2. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 whose claim for reimbursement for such services is denied or is not acted upon with reasonable promptness shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.
>
> 3. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is denied participation in any program or programs established under the provisions of chapter 208 shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.
>
> 4. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is aggrieved by any rule or regulation promulgated by the department of social services or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

§208.156.

The AHC did not have subject matter to hear and decide Hospitals' complaints in this case. First, jurisdiction was not conferred to the AHC pursuant to section 208.156.4. In their complaints, Hospitals, unlike the hospitals in ***Great Plains*** and the two companion

cases, did not challenge the validity of the Medicaid reimbursement cap on psychiatric services. The regulation imposing the cap had been withdrawn by DMS based on ***Great Plains*** prior to the filing of the complaints in this case. Instead, Hospitals sought additional reimbursements over the reimbursements they actually received in prior rate periods, and DMS denied their requests. An agency rule is a statement of policy or interpretation of law of future effect that acts on unnamed and unspecified persons or facts. ***Missouri Health Care Ass'n v. Missouri Dep't of Soc. Servs.*, 851 S.W.2d 567, 569 (Mo. App. W.D. 1993)**. Conversely, an agency decision engages the agency expertise on specific facts. ***Id.*** In this case, Hospitals sought review of DMS decisions—the denials of their claims for additional reimbursements—not of the validity of the psychiatric reimbursement cap as a matter of future policy without reference to named persons or facts. Section 208.156.4, which authorizes a hearing before the AHC for any person aggrieved by a rule or regulation of the Department of Social Services, therefore, did not apply.

Hospitals argue, however, that they are aggrieved by the enforcement of the former regulation for many years, and, thus, are entitled to a hearing before the AHC under section 208.156.4. They contend that the clause "who is aggrieved by any rule or regulation" within section 208.156.4 contemplates both current and past injury. In construing statutes, a court must endeavor to ascertain the intent of the legislature from the language used and give effect to that intent if possible. ***Great Plains*, 930 S.W.2d at 438**. "Legislative intent should be determined by considering the plain and

ordinary meaning of the terms in the statute." ***Id.*** Statutory construction is a question of law. ***Id.*** The plain and ordinary meaning of the clause in section 208.156.4 only encompasses present injury by a rule or regulation. If the General Assembly intended to confer jurisdiction to the AHC over cases where a person was injured or harmed in the past by a prior regulation and may continue to be injured into the present, it would have explicitly done so. Section 208.156.4, therefore, only gives the AHC jurisdiction in cases where a person is presently injured by an existing rule. At the time Hospitals filed their complaints with the AHC, the regulation that Hospitals claim injured them was no longer in existence. Section 208.156.4, therefore, did not confer jurisdiction to the AHC in this case.

Likewise, jurisdiction was not conferred to the AHC pursuant to subsection 2 of section 208.156. At about the same time Hospitals filed their complaints with the AHC, they sent letters to DMS demanding additional reimbursements for the period January 1, 1990, through June 30, 1995, based on the ***Great Plains*** decision. It appears that Hospitals filed their complaints with the AHC within 30 days of DMS's decisions denying their demands for additional reimbursement as required by section 208.156.8.[5] The AHC, however, found that Hos-

[5]Section 208.156.8 provides, in pertinent part:

> Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review with the administrative hearing commission.

§ 208.156.8.

pitals' demands were not timely filed under the DMS regulations and that Hospitals did not have a legal right to demand additional payments outside the normal rate-setting period. Thirteen CSR 70-3.100 establishes the general rules for submission or resubmission of claims and adjustments of claims to Missouri Medicaid. **13 CSR 70-3.100 (1998)**. It provides specific time periods for the filing by participating providers of original claims and adjustments to paid claims requesting Medicaid reimbursements. ***Id***. The time limit for filing an adjustment is provided in 13 CSR 70.3-100(6). Subsection six provides, "Adjustments to a paid claim must be filed within eighteen (18) months from the date of payment." **13 CSR 70-3.100(6)**. In this appeal, Hospitals do not contest the AHC ruling that their claims for additional reimbursements were untimely under 13 CSR 70-3.100(6). The issue is, therefore, abandoned. ***Kabir v. Missouri Dep't of Soc. Servs.*, 845 S.W.2d 102, 102-103 (Mo. App. W.D. 1993)**. The AHC did not obtain jurisdiction in this case based on section 208.156.2.

Although Hospitals were foreclosed from bringing this case on jurisdictional grounds, Hospitals had a prior mechanism to assert their claims. In section 208.156.4, the General Assembly provides a procedure to contest a rule or regulation as enacted to determine its legal validity. Had Hospitals brought complaints challenging the validity of the psychiatric cap regulation during the time when the regulation was in effect, as did the hospitals in ***Great Plains*** and the two companion cases, the AHC would have had jurisdiction over the complaints pursuant to section 208.156.4. § **208.156.4; *Great Plains*, 930 S.W.2d at 438**. Additionally, the General Assembly provides a remedy under section 208.156.2 for providers whose timely claims to

DMS are denied. Had Hospitals timely submitted their claims for adjustments under the regulations and then filed their complaints with the AHC within 30 days of DMS's denial of those claims, the AHC would have had jurisdiction in the case. §§ **208.156.2 and 208.156.8**; ***Livingston Manor*, 809 S.W.2d at 157.** To hold otherwise would allow providers to demand additional reimbursements from the State indefinitely for prior rate periods after regulations have been modified or withdrawn or payments have been made. Such a policy would confound the budgetary process of state government. Additionally, allowing providers to file claims indefinitely and to effectively force DMS to issue a new decision denying the claims, which would provide the basis for a new appeal period under section 208.156.2, would have the affect of negating the 30-day requirement of section 208.156.8.

The AHC abused its discretion in finding that it had subject matter jurisdiction in this case. The judgment of qòe circuit court reversing the decision of the AHC is affirmed.

Robert G. Ulrich, J.

All concur.

APPENDIX B

BEFORE THE ADMINISTRATIVE
HEARING COMMISSION
STATE OF MISSOURI

No. 96-002218 SP

NME HOSPITALS, INC., d/b/a
LUTHERAN MEDICAL CENTER,
Petitioner,

vs.

DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,
Respondent.

MEMORANDUM AND ORDER

On October 29, 1996, NME Hospitals, Inc., d/b/a Lutheran Medical Services (NME) filed a complaint alleging that it is entitled to additional Medicaid payments from the Department of Social Services, Division of Medical Services (Department) under section 208.156.4. On December 12, 1996, NME filed a first amended complaint alleging that it is entitled to additional payments under 208.156.2, .4, and .8. On April 9, 1997, NME filed a motion for summary determination. On June 23, 1997, the Department filed a response, and its own motion for summary determination.

After completion of the briefing, this Commission convened a hearing for oral argument on the motions on January 7, 1998. Richard D. Watters, with Lashly & Baer, represented NME. Paul G. Taylor, with Myers,

Taylor & Whitworth, represented amici Missouri Healthcare System, L.P., and Columbia Independence Regional Hospital. Terry C. Allen, with Allen & Holden Law Offices, L.L.C., represented amici Baptist Medical Center, Menorah Medical Center, Park Lane Medical Center, Trinity Lutheran Hospital, and Truman Medical Center. Kathleen Knepper represented the Department. The matter became ready for our decision on January 28, 1998, the date the transcript was filed.

We may decide this case without a hearing if either party shows undisputed facts that the other party does not dispute and that entitle that party to a favorable decision. Section 536.073.3, RSMo Supp. 1997.[1] ***ITT Commercial Fin. Corp. v. Mid-Am. Marine Supply Corp.***, 854 S.W.2d 371, 380-82 (Mo. banc 1993).

Consolidation

By order dated July 18, 1997, we consolidated this case with the following for the purposes of resolving similar legal issues: St. Louis University, d/b/a St. Louis University Hospital Medical Center (No. 96-002272 SP); Deaconess Health Services Corp., d/b/a Deaconess Hospital (No. 96-002315 SP); St. Luke's Northland Hospital Corp. (No. 96-002374 SP); St. John's Regional Health Center (No. 96-002444 SP); Psychiatric Healthcare Corp. of Missouri, d/b/a Lakeland Regional Hospital (No. 96-002663 SP); Southeast Missouri Hospital Assoc., d/b/a Southeast Missouri Hospital (No. 97-000109 SP); BHCA of Kansas City, Inc. d/b/a ValueMark Behavioral Healthcare of Kansas City, d/b/a North Hills Hospital (No. 97-000165 SP); St. John's Regional Medical Center

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[1]All statutory references, unless otherwise noted, are to the 1994 Revised Statutes of Missouri.

(No. 97-000257 SP); Deaconess Medical Center-West Campus (No. 97-000279 SP); and Lucy Lee Hospital (No. 97-000696 SP).[2] These cases are also being decided this day.

Findings of Fact

1. NME is, and was at all relevant times, a licensed hospital and authorized Medicaid provider.

2. Between January 1, 1990 and June 30, 1995 (the period), the Department reimbursed NME pursuant to a blended per diem reimbursement rate[3] calculated pursuant to the Hospital Reimbursement Plan except for psychiatric services. Psychiatric services cost less to provide than other hospital services.

3. The blended rate reimbursed providers at the same rate regardless of the type of care provided. It divided the total allowable Medicaid inpatient costs by its total Medicaid inpatient days. For example, if the average cost per day of caring for an ICU patient was $600, the average cost per day of caring for an obstetrics unit patient was $400 and the average cost per day for caring for a psychiatric unit patient was $200 per day, the state would average these numbers to determine the per diem rate of $400.[4]

4. During the period, the Department placed a "psych cap" on reimbursement of the per diem rate of inpatient psychiatric services pursuant to its Regulation 13 CSR 70-15.010(15). Thus, a provider would be paid for the

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[2]Other cases listed in that order have been dismissed.

[3]All rates are per patient day.

[4]This example assumes that there are exactly the same number of days in each unit.

covered psychiatric services at the lower of its blended rate or at the psych-capped rate. The Department continued to include the lower-cost psychiatric services costs in the blended rate, thus keeping the blended rate lower. In the above example, the provider would be paid $200 per day per the psych cap. However, the Department still used the lower cost figure in computing the average; so the provider would only be paid $400 per day for the $600 ICU patient.

5. Regulation 13 CSR 70-15.010(15) was declared invalid and void by the Circuit Court of Cole County, and by the Western District Court of Appeals in ***Missouri Dep't. of Soc. Servs. v. Great Plains Hosp., Inc.***, 930 S.W.2d 429 (Mo.. App., W.D. 1996) (***Great Plains***).[5] The Western District Court of Appeals ordered the Department to reimburse Great Plains Hospital for the difference between what it had received for inpatient psychiatric services under the psych cap per diem rate and what it would have received without the cap. Great Plains Hospital was reimbursed for this amount beginning with the adoption date of the regulation - January 1, 1990.

6. NME sent a "demand letter" to the Department on October 29, 1996, notifying the Department that it was seeking additional payment for inpatient psychiatric services during the period. The Department responded to the letter on November 27, 1996, denying further reimbursement.

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[5]The court also made this determination in companion cases ***Missouri Dep't of Soc. Servs. v. Alexian Brothers of St. Louis, Inc.***, 930 S.W.2d 439 (Mo. App., W.D. 1996) and ***Missouri Dep't of Soc. Servs. v. Trinity Lutheran Hosp.***, 930 S.W.2d 426 (Mo. App., W.D. 1996).

7. NME seeks $12,481,137 in additional payments from the Department. This is the amount that NME would have received under the blended rate had the Department not imposed the psych cap.[6]

Conclusions of Law

I. Procedural Issues

A. Objection to Affidavit

At the hearing, the Department made a motion to supplement the record to file the same documentary factual information for the other providers as was filed for NME. NME did not object to the filing of similar records. On January 22, 1998, the Department filed records including an affidavit of Jack Dothage. On January 28, 1998, NME filed a motion to strike the affidavit because it exceeds the information originally filed in that it includes claims that are unrelated to Medicaid and beyond the scope of the complaint. On January 30, 1998, the Department and all consolidated parties entered into a joint stipulation, and NME withdrew the motion to strike.

B. Objection to Affirmative Defenses

NME argues that the Department is precluded from arguing statutes of limitation afforded by sections 33.120[7] and 516.120 as affirmative defenses because such defenses were not pleaded in its answer. Our Regulation 1 CSR 15-6.380(2)(C)

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[6]The Department has accepted NME's calculation of the reimbursement shortfall due to imposition of the psych cap.

[7]The relevant portion of the statute is virtually unchanged in the 1997 Supplement.

provides that the answer shall "[a]ssert as a defense any specific failure of the complaint to comply with 1 CSR 15-6.350 or waive that defense by not asserting it[.]"

That regulation relates to failure of the complaint. The statute of limitation defense is not a defense related to that regulation. The Department has asked for leave to amend its answer to include the affirmative defenses, and we grant such leave.

II. Jurisdiction

NME claims that we have jurisdiction to hear its petition under sections 621.055 and 208.156.2, .4, and .8.

A. Aggrieved by Regulation

The Department argues that we lack jurisdiction to hear NME's petition under section 208.156.4 because the regulation in question was declared void in ***Great Plains*** and was withdrawn before NME filed its complaint. NME argues that it was aggrieved while the rule was in effect and is still aggrieved because it has not been paid. Thus, we have jurisdiction under section 208.156.4, which provides:

> 4. Any person authorized under section 208.153 to provide [Medicaid] services . . . who **is aggrieved by any . . . regulation promulgated by the department of social services** or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

(emphasis added), and section 621.055, which provides:

> Any person authorized under section 208.153, RSMo, to provide [Medicaid] services . . . may seek review by the administrative hearing commission of any of the actions of the department of social services specified in subsection 2, 3, or 4 or section 208.156, RSMo. The review may be instituted by the filing of a petition with the administrative hearing commission.

NME asserts that it is not seeking a retroactive rate increase, but is claiming that it is aggrieved by a regulation. We agree with NME. The regulation may not exist anymore, but NME still has a claim that it is aggrieved due to the enforcement of the regulation for many years. The Department withheld money from NME based on an invalid regulation. This is money that NME at least has the right to argue was wrongfully denied.

We conclude that we have jurisdiction to hear NME's complaint under sections 621.055 and 208.156.4. NME has the burden of proving that it is entitled to additional reimbursement. Section 621.055.1.

B. Appealing a Denied Claim

NME also argues that we have jurisdiction to hear its complaint because it is appealing a final decision from the Department. Section 208.156 provides:

> 2. Any person authorized under section 208.153 to provide services for which benefit payments

> are authorized under section 208.152 whose claim for reimbursement for such services is denied or is not acted upon with reasonable promptness shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.
>
> • • •
>
> 8. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review with the administrative hearing commission . . .

NME contends that the demand letter to the Department, mailed on October 29, 1996, constitutes a claim for reimbursement that was denied by the Department. The Department argues that a provider does not have a right to demand additional payments outside of the normal rate-setting period,[8] and the denial of such a demand does not trigger a new 30-day period within which the provider may appeal an old rate. We agree with the Department. If the Department could be forced to issue a new decision -- and provide the basis for a new appeal period -- at the provider's whim, it would render the 30-day provision meaningless.

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[8]The Department cites its Regulation 13 CSR 70-3.100(6), which gives the provider 18 months from the Department's payment to seek adjustment of the claim.

See ***BHCA of Kansas City, Inc. v. Department of Soc. Servs.***, No. 96-000020 SP (Admin. Hearing Comm'n Nov. 3, 1997).

We find that we do not have jurisdiction to hear NME's petition under section 208.156.2 and .8.

III NME Not Party to Great Plains Case

The Department argues that NME is not entitled to relief *per se* as a result of the ***Great Plains*** decision because NME was not a party to the previous cases and because the cases were not filed as a class action suit. This is true; the prior decision only binds the parties. However, nothing prohibits NME from bringing its own action to determine whether it is entitled to the same or similar relief. We find that NME is not automatically entitled to the relief granted in ***Great Plains*** as a result of that decision, but that NME is not foreclosed from filing a complaint to determine whether it is entitled to relief under the same or similar legal theory.

IV Sovereign Immunity Waiver

The Department argues that NME's claims are barred by sovereign immunity that the State has not waived. Waivers of sovereign immunity must by strictly construed. ***Community Fed. Sav. & Loan Ass'n v. Director of Revenue***, 752 S.W.2d794, 796 (Mo. banc 1988). In this case, sovereign immunity has been expressly waived by statute. Section 208.156.2, .3 and .4 authorizes a hearing before this Commission if a provider has been denied reimbursement or participation in a program or is aggrieved by a rule or regulation. Section 621.055 authorizes us to order monetary relief, with interest, for any amount we find has been wrongfully denied or withheld.

In many cases before us, we have determined that the rate paid to a particular provider was legally insufficient and have ordered the Department to pay more money. This is what the statutes authorize us to do; the statutory remedy offered to the providers would be meaningless if the Department could raise the sovereign immunity defense to avoid every payment for reimbursement of money wrongfully withheld.

V. Section 33.120

Claims Barred Unless Presented Within Two Years

The Department argues that NME's claim is barred by the two-year statute of limitations found in section 33.120, which states:

> Persons having claims against the state shall exhibit the same, with the evidence in support thereof, to the commissioner of administration, for his approval, within two years after such claims accrue, and not thereafter.

However, as NME points out, the Commissioner of Administration has no control over Medicaid payments, other than to approve the total amount of all claims. Control over Medicaid cases is vested exclusively in the Department. The Medicaid money is held separate from the Commissioner of Administration's fund of public money. Section 208.170.2. Section 208.170.8 provides:

> The Title XIX fund shall consist of moneys appropriated by the state and such money as may be received from the federal government or other sources for the payment of medical assistance rendered to eligible recipients pursuant to the Title XIX state plan, and all checks payable on behalf of

> recipients shall be drawn on and paid from this fund.

The statutes have set forth a method for appealing Medicaid payments that the provider believes have been wrongfully withheld. Nowhere in the statutory scheme is it deemed necessary to apply to or exhibit the claim to the Commissioner of Administration. We find that the two-year statute of limitation under section 33.120 does not bar any portion of NME's claim.

VI. Chapter 516

The Department argues that NME's claim is barred by the five-year statute of limitation found in section 516.120. NME argues that this statute of limitations does not apply because Chapter 208 sets forth the complete and exclusive procedure for Medicaid and that any limitation period, such as the 30-day statute of limitation to file an appeal from the Department's decisions, must be established within that chapter. NME states that if any statute of limitation in Chapter 516 applies, it would be the ten-year statute of limitation found in section 516.110.

Section 516.100 describes the actions subject to the differing statutes of limitation:

> **Civil actions, other than those for the recovery of real property, can only be commenced within the periods prescribed in the following sections**, after the causes of action shall have accrued; provided, that for the purposes of sections 516.100 to 516.370, the cause of action shall not be deemed to accrue when the wrong is done or the technical breach of contract or duty occurs, but when the damage resulting therefrom is sustained

and is capable of ascertainment, and, if more than one item of damage, then the last item, so that all resulting damage may be recovered, and full and complete relief obtained.

(Emphasis added.)

Section 516.110 sets forth a ten-year statute of limitation as follows:

Within ten years:

(1) An action upon any writing, whether sealed or unsealed for the payment of money or property;

(2) Actions brought on any covenant or warranty contained in any deed of conveyance of land shall be brought within ten years next after there shall have been a final decision against the title of the covenantor in such deed, and actions on any covenant of seizin contained in any such deed shall be brought within ten years after the cause of such action shall accrue;

(3) Actions for relief, not herein otherwise provided for.

Section 516.120 sets forth a five-year statute of limitation as follows:

Within five years:

(1) All actions upon contracts, obligations or liabilities, express or implied, except those mentioned in section 516.110, and except upon judgments or decrees of a court of record, and except where a different time is herein limited;

(2) An action upon a liability created by a statute other than a penalty or forfeiture;

(3) An action for trespass on real estate;

(4) An action for taking, detaining or injuring any goods or chattels, including actions for the recovery of specific personal property, or for any other injury to the person or rights of another, not arising on contract and not herein otherwise enumerated;

(5) An action for relief on the grounds of fraud, the cause of action in such case to be deemed not to have accrued until the discovery by the aggrieved party, at any time within ten years, of the facts constituting the fraud.

While NME and the Department argue whether the action should be considered an action upon a contract under section 516.120 (1) or an action upon any writing under section 516.110, this Commission believes that the logical placement for an action to recover money owed under Medicaid statutes would be section 516.120(2)-"[a]n action upon a liability created by a statute other than a penalty or forfeiture[.]"

However, because of the language in section 516.100, we find that neither 516.110 nor 516.120 applies in this case. Section 516.100 states that the limitation on filing suit will apply to "civil actions." While this could be read broadly to mean any action that is not criminal, the number of times that the legislature and the courts distinguish between civil actions and administrative agency proceedings convince us that the two have separate meanings.

This Commission is an agency as defined by section 536.010(1). We hear contested cases, "proceeding[s] before an agency in which legal rights, duties or privileges of specific parties are required by law to be determined after hearing[.]" Section 536.010(2). Chapter 536, not the Missouri Rules of Civil Procedure, sets forth our procedures. The statute authorizing the granting of attorney fees makes the distinction between agency proceedings and civil actions:

> A party who prevails in an **agency proceeding or civil action** arising therefrom, brought by or against the state, shall be awarded those reasonable fees and expenses incurred by that party in the **civil action or agency proceeding**, unless the court or agency finds that the position of the state was substantially justified or that special circumstances make an award unjust.

Section 536.087.1 (emphasis added). *See also* ***State ex rel. Div. of Transp. v. Sure-Way Transp., Inc.***, 948 S.W.2d 651, 655-57 (Mo. App., W.D. 1997) (which found that the **civil** penalty **action** arises from the **agency proceeding**).

The court in ***Davis v. Board of Educ. of City of St. Louis***, 1998 WL 36927 (Mo. App., E.D. Feb. 3, 1998) (transfer denied Apr. 22, 1998), stated that administrative actions have characteristics that separate them from both criminal and civil actions. The court stated that the administrative action does not result in possible imprisonment like a criminal action. However, the administrative action is also different from the civil action in that it can be penal in nature, prosecuted for the benefit of the public rather than the individual. *Id.*

The court in ***Reed v. City of Springfield***, 841 S.W.2d 283, 285 (Mo. App., S.D. 1992) referred to a decision by the Springfield Mayor's Commission on Human Rights and Community Relations that was followed by a petition for judicial review as a civil action for the purposes of section 514.060, but did not elaborate on its reasoning.

The only case we find in which the court applied a section 516.100 statute of limitation to a case that had before been an administrative agency is ***De Paul Hosp. School of Nursing, Inc. v. Southwestern Bell Telephone Co.***, 539 S.W.2d 542,546 (Mo. App., St.L.D. 1976). This case involved an action to recover damages, with interest, for rate overcharges that had been determined at the Public Service Commission. However, in that case, the Public Service Commission only decided the rate. The damages for overcharges were awarded by a court in civil action.

We conclude that a contested case is not a civil action, and thus, the section 516.110 and 516.120 statutes of limitation do not apply to bar NME from filing its claim.

VII. Reasonableness of Total Amount Paid

The Department asks us to consider that, even with the imposition of the psych cap, the rate paid to NME was a fair and reasonable rate. The court in ***Great Plains Hosp.***, 930 S.W.2d at 438, however, declined to consider the substantive question of total reimbursement, finding that the provider was "entitled to reimbursement for their Medicaid services under a validly promulgated plan." As ***Great Plains*** suggests, if we find that NME is entitled to reimbursement, we will simply require the Department to reimburse NME

"according to its last, validly enacted payment plan." *Id.* This plan, according to the ***Great Plains*** court, used the blended rate without the psych cap.

We note that there was no record made and no evidence presented showing that NME was paid less than is reasonable and adequte to meet the costs that an efficiently and economically operated facility must incur to provide care meeting legal standards.

VIII. Substantial Hardship to the State Finances

The Department argues that it would be ridiculous and dangerous to the State's finances to have no statute of limitation that covers an attack on a regulation such as this one. The Department points out that a party could go back twenty or thirty years and attack a regulation. However, section 208.156.4 gives a party the right to attack a regulation if "aggrieved" by it, but does not include a time frame within which the party must do so. We have set forth our reasons for finding that none of the statutes argued by the parties limit NME's action. We have searched for a "default" statute of limitation that would establish a time limit for filing any type of case that does not have its own specific statute, but can find none.

We are aware of the amount of money involved in this case and other similar cases being decided today. The Department asserts that payment of these claims will constitute a substantial hardship on the State. However, we must follow the Western District Court's prior rulings. In ***Missouri Dep't of Soc. Servs. v. Trinity Lutheran Hosp.***, 930 S.W.2d 426, 429 (Mo. Ap., W.D. 1996), the court stated that this Commission is required "to take judicial notice that the psychiatric cap [has]

been declared invalid . . .and to decide the case before it accordingly." We do not believe that we have the authority to act as the court did in ***Jones v. State Highway Comm'n***, 557 S.W.2d 225 (Mo. banc 1977), when it set forth conditions and limits on recovery under which it was abrogating sovereign immunity "in order that an orderly transition be made, that adequate financial planning take place, that governmental units have time to adjust their practices and that the legislature be afforded an opportunity to consider the subject in general." *Id.* at 231.

Summary

This Commission therefore concludes that the State waived sovereign immunity by authorizing this Commission to determine Medicaid rates, and that no statute of limitation applies to limit recovery. Because the psych cap was declared invalid in ***Great Plains***, and because ***Trinity Lutheran*** affirms our responsibility to apply this legal conclusion in other cases, we find that NME is entitled to reimbursement of the $12,481,137 that the Department withheld due to imposition of the invalid psych cap.

SO ORDERED on May 12, 1998.

/s/ Willard C. Reine
WILLARD C. REINE
Commissioner

APPENDIX C

IN THE CIRCUIT COURT OF COLE COUNTY
STATE OF MISSOURI

MISSOURI DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,
Plaintiff,

vs.

NME HOSPITAL, INC.
d/b/a LUTHERAN MEDICAL CENTER, et.al.,
Respondent.

Case No. CV198-783CC
Consolidated with:
CV198-784CC
CV198-785CC
CV198-786CC
CV198-787CC
CV198-788CC
CV198-789CC
CV198-790CC
CV198-791CC
CV198-792CC
CV198-793CC
CV 198-1299CC
CV198-1481CC

JUDGMENT AND ORDER

This case is brought before this Court for consideration of the Petitions for Judicial Review which were filed by the Department of Social Services, Division of Medical Services under 536.140 RSMo. in thirteen (13)

cases that have now been consolidated in case number CV198-783CC. The hospitals that are the Respondents herein filed complaints at the Administrative Hearing Commission on or after October 29, 1996, citing the decision in *Mo. Dept. of Social Services vs. Great Plains Hospital, Inc.*, 930 SW.2d 429 (Mo. App. W.D. 1996).[1] In that case, the Court of Appeals affirmed the decision of the Circuit Court of Cole County issued by amended order on September 7, 1995, finding a regulation of the Department which placed an upper limit or "cap" on the Medicaid rate for inpatient psychiatric services void and invalid from the date of its adoption on January 1, 1990.

The hospitals filed Motions for Summary Determination at the Administrative Hearing Commission in which they argued that they were entitled to additional payment from the State as a consequence of the decision in the *Great Plains* case. The agency filed a response to the hospitals' Motion for Summary Determination, which also served as the Department's Cross Motion for Summary Determination.

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[1]In addition to NME Hospital, Inc. d/b/a Lutheran Medical Center, the hospitals that are consolidated as Respondents in this case are: St. Louis University, d/b/a St. Louis University Medical Center; Deaconess Health Services Corp., d/b/a Deaconess Hospital; St. Luke's Northland Hospital Corp.; St. John's Regional Health Center; Psychiatric Healthcare Corp. of Missouri, d/b/a Lakeland Regional Hospital; Southeast Missouri Hospital Assoc., d/b/a Southeast Missouri Hospital; BCHA of Kansas City, Inc., d/b/a ValueMark Behavioral Healthcare of Kansas City, d/b/a North Hills Hospital; St. John's Regional Medical Center; Deaconess Medical Center-West Campus; Lucy Lee Hospital Truman Medical Center, Inc., d/b/a Truman Medical Center-East; and Missouri Healthcare System, LP.

The Department contended that the Administrative Hearing Commission lacked subject matter jurisdiction to hear the hospitals' Complaints. The Department also argued that the claims of the hospitals are barred by sovereign immunity and by certain statutes of limitations.

The Administrative Hearing Commission found on behalf of the hospitals that jurisdiction was conferred on the basis of 208.156.4 RSMo and that the statutory scheme set forth in section 208 functions as a complete waiver of the state's immunity. The Administrative Hearing Commission found as well that no statute of limitations applies to limit the period within which these providers could receive retroactive payments from the State. In so deciding, the Administrative Hearing Commission denied the Department's Cross Motion for Summary Determination.

The Department filed Petitions for Judicial Review in each case. On motion of the Department and without objection from the hospitals, the cases were consolidated.

The three attorneys representing the Respondents were afforded an opportunity to respond to the Department's Opening Brief and to participate in oral argument on December 22, 1998. The matters before the Court are matters of law and the Court considers these matters anew. *Dixon vs. Holden*, 923 S.W.2d 370 (Mo. App. W.D. 1996), *Thomas vs. Mo. Dept. of Social Services*, 805 S.W.2d 286 (Mo App. 1991). I reverse.

The Court finds that the Administrative Hearing Commission did not have jurisdiction to consider these cases. The hospitals bear the burden of demonstrating that they meet the jurisdictional requirement set forth

in 208.156.4 RSMo. Under 208.156.4 RSMo, jurisdiction is conferred in circumstances in which a "person authorized...to provide services...is aggrieved by any rule or regulation promulgated by the department of social services...(emphasis added)" Jurisdiction is not herein conferred under 208.156.4 RSMo because the regulation in question was not in effect at the time the complaints of the hospitals were filed. The regulation had been found void and invalid from the date of its adoption by Order of this Court issued on September 7, 1995, which order was affirmed on June 21, 1995 in *Mo. Dept. of Social Services vs. Great Plains Hospital, Inc.* 930 S.W.2d 429 (Mo. App. W.D. 1996). The Missouri Supreme Court on October 22, 1996 declined to review the case. In confirmatory action, the rule was formally withdrawn by the agency by emergency rulemaking, effective on October 1, 1996. As such, the rule was not in effect when the complaints were filed.

Under these circumstances, the Court finds that the Respondents were not aggrieved by the application of a rule of the Department at the time they sought to invoke the jurisdiction of the AHC. The Court finds that the intent of 208.156.4 RSMo. is to enable Medicaid providers to seek review of the construction and application of existing rules and not to enable providers to seek additional payments from the State for prior rate periods when a rule that is no longer valid had been applied. The Administrative Hearing Commission's construction of 208.156.4 RSMo. would have the effect of negating the other provisions of the statute, specifically including 208.156.8 RSMo.

The Court agrees with the Administrative Hearing Commission that jurisdiction was not conferred under 208.156.2 and 208.156.8 in that the hospitals did not

file their complaints within thirty days of any rate decision of the Department.

The Court notes that counsel representing many of the hospitals submitted a written document to the Court following oral argument in this case. The Court is not persuaded by the argument being raised. Counsel for the hospitals suggests that after the expiration of the emergency rulemaking by which the challenged rule was withdrawn and before the final rulemaking took effect, there was a lapse period between March 29, 1997, and April 30, 1997, when the rule was technically still "on the books." Even if this is true, no hospital could have been "aggrieved" by it because there is no allegation that the void rule was applied to the Medicaid rates of the hospitals any time after October 1, 1996.

In light of the Court's decision, it is unnecessary to reach the other issues that have been raised by the parties.

JUDGMENT AND ORDER

The decision of the Administrative Hearing Commission is reversed. The Administrative Hearing Commission lacked subject matter jurisdiction to hear the complaints of the hospitals and should have dismissed these cases. It is so ordered.

/s/ Thomas J. Brown
The Honorable Thomas J. Brown
January 8, 1999

Supreme Court, U.S.
FILED
JUL 20 2000
CLERK

(2)

No. 99-2031

IN THE
Supreme Court of the United States
October Term, 2000

NME HOSPITAL, INC., ET AL.,

Petitioners,

v.

MISSOURI DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE MISSOURI COURT OF APPEALS
FOR THE WESTERN DISTRICT

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the Missouri Court of Appeals for the Western District erroneously interpreted Mo. Rev. Stat. § 208.156 as not granting jurisdiction to the state Administrative Hearing Commission to review challenges to state Medicaid regulations after they have been repealed?

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

STATEMENT 1

REASONS WHY THE PETITION SHOULD BE DENIED .. 5

CONCLUSION 11

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Alden v. Maine, 119 S. Ct. 2240 (1999) 6

Bacchus Imports, Ltd. v. Dias, 468 U.S. 263 (1984) 7

Harper v. Virginia Department of Taxatio, 509 U.S. 86 (1993) 8

Harris v. McRae, 448 U.S. 297 (1980) 1

James B. Beam Distilling Co. v. Georgia, 501 U.S. 529 (1991) 7, 8, 9, 10

McKesson Corp. v. Division of Alcoholic Beverages and Tobacco, 496 U.S. 18 (1990) 9, 10

Reich v. Collins, 513 U.S. 106 (1994) 9

Reynoldsville Casket Co. v. Hyde, 514 U.S. 749 (1995) 8, 9

STATE CASES

Americare Properties, Inc. v. Chronister, No. 76,046 (Kan. App. Mar. 17, 1997), *aff'd*, 934 P.2d 139 (1997) 6

Matter of Brothers of Mercy Nursing and Rehabilitation Center v. Commissioner, 192 A.D.2d 50, 600 N.Y.S.2d 174 (App. Div. 1993) 6

Golden Five, Inc. v. Department of Social Services, 229 Neb. 148, 425 N.W.2d 865 (Sup. Ct. Neb. 1988).....6

IFIDA and Kent Convalescent Center v. Division of Social Serv., C.A. No. 93A-04-019, 653 A.2d 305 (Del. Super. 1994).....6

Livingston Manor, Inc. v. Department of Social Services, Division of Family Services, 809 S.W.2d 153 (Mo. App. 1991).....4, 5

Missouri Department of Social Services v. Alexian Brothers Hospital, 930 S.W.2d 439 (Mo. App. 1996).....4

Missouri Department of Social Services v. Great Plains Hospital, Inc., 930 S.W.2d 429 (Mo. App. 1996).....3

Missouri Department of Social Services v. Trinity Lutheran Hospital, 930 S.W.2d 426 (Mo. App. 1996).....4

Missouri Health Care Association v. Missouri Department of Social Services, 851 S.W.2d 567 (Mo. App. 1993).....5

Westshire Retirement and Healthcare Center v. Department of Public Aid, 276 Ill. App. 3d 514, 658 N.E.2d 1286 (1995).....6

Williams v. Hank's Ambulance Service, 699 So. 2d 1230 (Ala. S.Ct. 1997).....6

FEDERAL STATUTES AND REGULATIONS

42 C.F.R. § 447.253(e) 1, 6

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, ... 1

42 U.S.C. § 1396a(a)(13)(A) (repealed) 3

STATE STATUTES AND REGULATIONS

Mo. Rev. Stat. § 208.156 ..... *passim*

Mo. Rev. Stat. § 621.015 2

13 C.S.R. 70-15.010(15) 3

13 C.S.R. 70-15.010(16) 3

RESPONDENT'S BRIEF IN OPPOSITION

Respondent Missouri Department of Social Services, Division of Medical Services ("Department" or "State"), respectfully requests that this Court deny the petition for a writ of certiorari in this case. That opinion is reported at 11 S.W.3d 776 and reproduced in the Appendix to the Petition at A-1.

STATEMENT

Respondent is the state agency in Missouri responsible for administering the State's Medicaid program. Petitioners are eleven hospitals that have elected to participate in Missouri Medicaid.

1. The Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, is a cooperative federal-state public assistance program that provides federal financial assistance to participating States "to aid them in furnishing health care to needy persons." *Harris v. McRae*, 448 U.S. 297, 308 (1980); *see* 42 U.S.C. § 1396. The Medicaid program is administered by the States, subject to certain federal guidelines.

Health care providers that choose to participate in a State's Medicaid program are entitled to receive the payment rates set by the State for services provided to Medicaid enrollees. Among other things, federal regulations require state Medicaid agencies to:

> provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 C.F.R. § 447.253(e).

In Missouri, health care providers may seek review of Medicaid payment rates before the state Administrative

Hearing Commission ("AHC"), which is an independent administrative body tasked by statute with review of various agency actions, including actions by the Department. *See* Section 621.015 *et seq.*, RSMo. In the context of Medicaid, the Missouri General Assembly has given the AHC jurisdiction with respect to the following:

- an action by a provider "whose claims for reimbursement for such services is denied or is not acted upon with reasonable promptness" (§ 208.156.2, RSMo)

- an action by a provider "who is denied participation in any [departmental] program or programs" (§ 208.156.3, RSMo)

- an action by a provider "who is aggrieved by any rule or regulation promulgated by the department of social services or any division therein" (§ 208.156.4, RSMo)

- an action by a provider "who is aggrieved by any rule or regulation, contractual agreement, or decision . . . by the department of social services or any division therein" (§ 208.156.5, RSMo)

Petitions for review before the AHC must generally be filed within "thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division." § 208.256.8, RSMo. Appeals from AHC decisions are available to state Circuit Court and then to the state Court of Appeals and, if transfer is granted, to the Missouri Supreme Court.

2. Effective January 1, 1990, the Department adopted a regulation which established an upper limit on the per diem payment that was allowed for certain inpatient psychiatric services provided by hospitals that participate in the Medicaid

program.[1] The Department adopted this rate (the "psychiatric cap") in an effort to control unexplained growth that had occurred over a period of years in claims for inpatient psychiatric services.

In 1990, shortly after the cap went into effect, Great Plains Hospital brought suit alleging that the Department's adoption of the psychiatric cap had not complied with the procedural requirements of the so-called "Boren Amendment" to federal Medicaid law, 42 U.S.C. § 1396a(a)(13)(A) (repealed). While Great Plains' action was pending before the AHC, two other hospitals also filed petitions for review making the same allegations. Consistent with the thirty-day requirement of § 208.156.8, RSMo, the Trinity Lutheran and Alexian Brothers hospitals both brought suit within thirty days of receiving the determination as to their Medicaid rates for the fiscal year.

In July 1994, the AHC agreed with Great Plains Hospital that the Department's adoption of the cap on inpatient psychiatric services had not complied with the Boren Amendment's "procedural" requisites.[2] On appeal, the Cole County Circuit Court and later the Court of Appeals for the Western District, affirmed. *See Missouri Dep't of Soc. Servs. v. Great Plains Hosp., Inc.*, 930 S.W.2d 429 (Mo. App. 1996).

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[1] This regulation was initially codified at 13 CSR 70-15.010(15) and was later codified in the same form at 13 CSR 70-15.010(16).

[2] While it was in effect, the Boren Amendment was construed to have a "procedural" component—separate and apart from the "substantive" requirement that a State's Medicaid rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities"—that required States to "find[ ]" and "make[ ] assurances" that its Medicaid rates met the statutory requirements. *See* 42 U.S.C. § 1396a(a)(13)(A). Congress repealed the Boren Amendment as part of the Balanced Budget Act of 1997.

The Court of Appeals upheld the Circuit Court's award of additional payments to Great Plains hospital for inpatient psychiatric services dating back to January 1, 1990, without application of the payment cap. *Id.* On the same day, it also affirmed the Circuit Court's judgments awarding the Alexian Brothers and Trinity Lutheran hospitals additional Medicaid reimbursement from the time that each hospital filed its rate appeal, or October 1, 1992, and September 18, 1993, respectively. *Missouri Dep't of Social Servs. v. Alexian Bros. Hosp.*, 930 S.W.2d 439 (Mo. App. 1996), and *Missouri Dep't of Social Servs. v. Trinity Lutheran Hosp.*, 930 S.W.2d 426 (Mo. App. 1996).

On October 1, 1996, several months after the Court of Appeals' decision invalidating the psychiatric cap, the Department withdrew the regulation. Shortly thereafter, petitioners began to file petitions for review before the AHC claiming that they too were entitled to additional payments from the Department for the entirety of the period from January 1, 1990, until the time the payment cap on inpatient psychiatric services ceased to have effect.

The AHC found that it had jurisdiction to consider the petitioners' complaints under § 208.156.4, RSMo—which gives the Commission the authority to hear actions brought by a provider "who is aggrieved" by a departmental rule or regulation—and held that the psychiatric cap should not have applied to the State's Medicaid payment rates from 1990 onward. On appeal, the Circuit Court of Cole County reversed and the Court of Appeals for the Western District affirmed the reversal, both holding that as a matter of state law the AHC did not have jurisdiction to consider the case.

The Court of Appeals noted that "[t]he AHC is a creature of statute and 'has only such jurisdiction or authority as may be granted by the legislature'." 11 S.W.3d at 780, quoting *Livingston Manor, Inc. v. Department of Soc. Servs., Div. of Family Servs.*, 809 S.W.2d 153, 156 (Mo. App. 1991). The court held that AHC jurisdiction over actions in which a provider claimed to be "aggrieved by a rule or regulation" of

the Department is limited to challenges to "a statement of policy or interpretation of law *of future effect*." *Id.* (emphasis added), citing *Missouri Health Care Ass'n v. Missouri Dep't of Soc. Servs*, 851 S.W.2d 567, 569 (Mo. App. 1993). It held that "[i]f the General Assembly intended to confer jurisdiction to the AHC over cases where a person was injured or harmed in the past by a prior regulation . . . , it would have explicitly done so." *Id.* at 781. Because petitioners—unlike the hospitals in *Great Plains* and the two companion cases—"did not challenge the validity of the Medicaid reimbursement cap on psychiatric services" but instead only "sought additional reimbursement over the reimbursements they actually received in prior rate periods," the court concluded that the AHC did not have jurisdiction to review their complaint under 208.156.4. *Id.* at 780.[3]

The Missouri Supreme Court denied the motion for transfer on March 21, 2000.

REASONS WHY THE PETITION SHOULD BE DENIED

The petition should be denied because it does not present any question of federal law, much less a substantial question of the sort appropriate for review on certiorari.

1. Petitioners do not contend that the Missouri appellate court's construction of state law violates any provision of the federal Medicaid Act. Nothing in Title XIX either now or before the repeal of the Boren Amendment required States to award retroactive damages if a provider were to prevail in a challenge to Medicaid payment rates.

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[3] The Court of Appeals also agreed with the AHC and the Circuit Court that the AHC did not have jurisdiction to review the action under 208.156.2, RSMo, because the hospitals had not filed their claim within 30 days of a departmental rate decision. *Id.* at 781.

Certainly, no such requirement is found in 42 C.F.R. § 447.253(e), which provides only that State Medicaid Agencies must have an appeals process "with respect to such issues as the agency determines appropriate" and is silent as to what kinds of relief, if any, must be available.

The decision whether to award damages to health care providers in Medicaid rate challenges is left to the individual States, and is not one imposed by Congress. *Cf. Alden v. Maine*, 119 S. Ct. 2240 (1999) (Congress does not have Article I authority to abrogate state sovereign immunity in state court). The case law therefore has examples both of instances where state processes have awarded retroactive relief, and those where they have not. Petitioners cite examples only of the former category to this Court. See Petition at 14-15.

What petitioners do not discuss are the number of cases in which state courts, having found that a State's Medicaid rates did not conform to federal standards, granted prospective relief but nevertheless denied claims for retroactive rate increases either on grounds of sovereign immunity[4] or because the provider failed to comply with state administrative processes.[5]

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[4] *See, e.g., Williams v. Hank's Ambulance Serv.*, 699 So.2d 1230 (Ala. S.Ct. 1997) (holding that State had not waived its sovereign immunity in claims for retroactive reimbursement); *Westshire Retirement and Healthcare Center v. Department of Public Aid*, 276 Ill. App.3d 514, 658 N.E.2d 1286 (1995) (same).

[5] *See, e.g., Golden Five, Inc. v. Dep't of Soc. Servs.*, 229 Neb. 148, 425 N.W.2d 865 (Sup. Ct. Neb. 1988) (court cannot award retroactive rate increases for failure to comply with federal law when provider failed to timely appeal those rates through state administrative process); *Matter of Brothers of Mercy Nursing and Rehabilitation Center v. Commissioner*, 192 A.D.2d 50, 53 n.3, 600 N.Y.S.2d 174, 176 n.3 (App. Div. 1993) (same); *Americare Properties, Inc. v. Chronister*, No. 76,046, slip op. at 18 (Kan. App. (continued...)

The variation in these cases is not due to any disagreement as to what federal law requires but results only from the application of different state laws to different factual scenarios. In this case, the Missouri Court of Appeals for the Western District decided a question of state law—whether the state legislature had given the state Administrative Hearing Commission jurisdiction over provider claims for retroactive rate increases after the offending regulation has been repealed—that does not present a federal issue appropriate for review by this Court.

2. The *Beam* case relied upon by petitioners does not turn this state law question into a federal case. *James B. Beam Distilling Co. v. Georgia*, 501 U.S. 529 (1991), concerned whether a principle of law first announced by this Court in *Bacchus Imports, Ltd. v. Dias*, 468 U.S. 263 (1984), had to be given retroactive effect by Georgia state courts. The controversy centered on a Georgia statute that provided for different tax treatment for liquor manufacturers depending on whether those manufacturers were located in or out-of-state. *Beam*, 501 U.S. at 532. A similar law enacted by Hawaii had previously been declared unconstitutional by this Court in *Bacchus*. In light of *Bacchus*, the Georgia court held that the state statute was unconstitutional, but refused to apply the ruling retroactively since the statute was assumed to be constitutional for the years in which the State had collected the taxes. 501 U.S. at 533. In *Beam*, this Court held that because it had applied its ruling in *Bacchus* retroactively, the Georgia courts were also bound to apply the rule retroactively to

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Mar. 17, 1997), *aff'd*, 934 P.2d 139 (1997) (same); *cf. IFIDA and Kent Convalescent Center v. Division of Social Serv.*, C.A. No. 93A-04-019, 653 A.2d 305 (Del. Super. 1994) (unpublished), 1994 WL 632828 (state court does not have jurisdiction to review provider's challenge that State failed to comply with federal law).

similarly situated parties who were "not barred by procedural requirements or res judicata." 501 U.S. at 543, 544.

In their attempt to "federalize" this case, petitioners turn the holding of *Beam*—which the decision itself called a "narrow" one, 501 U.S. at 544—into a sweeping requirement that would require state courts to grant retroactive relief in virtually all circumstances where some other party somewhere has previously been awarded such relief. *Beam* in no way imposes such a federal requirement on state court adjudication.

First, as subsequent cases have explained, *Beam* is a Supremacy Clause case: it sets forth the obligations of state courts to follow the decisions of this Court, and holds that this Court's application of a rule of federal law to the parties before it requires every court, including state courts, to give retroactive effect to that decision. *See Harper v. Virginia Department of Taxation*, 509 U.S. 86, 96 (1993); *Reynoldsville Casket Co. v. Hyde*, 514 U.S. 749, 751 (1995). As the Court stated in *Harper*: "The Supremacy Clause . . . does not allow federal retroactivity doctrine to be supplanted by the invocation of a contrary approach to retroactivity under state law. Whatever freedom state courts may enjoy to limit the retroactive application of their own interpretations of state law, . . . cannot extend to their interpretations of federal law." 509 U.S. at 100; *see also Reynoldsville Casket*, 514 U.S. at 751 (state court's refusal to follow this Court in applying a rule of federal law retroactively "violates the Constitution's Supremacy Clause").

In this case, there is no Supremacy Clause issue, because this Court has never held that procedural violations of the Boren Amendment require retrospective relief. The Missouri Court of Appeals' retroactive fee awards to the Great Plains, Alexian Brothers, and Trinity Lutheran hospitals in 1996 was based on a question of state law—*i.e.*, whether and on what bases the AHC had jurisdiction to review their challenges to the psychiatric cap—not federal law. 930 S.W.2d at 431. The Supremacy Clause, and the *Beam* case,

therefore have no bearing on that court's subsequent interpretation of the same state law.

There is another, independent reason, that the federal retroactivity doctrine of the *Beam* case does not apply here. As the Court stated in both *Beam* and *Reynoldsville Casket*, general principles of retroactivity do not require a state court to overlook or overcome procedural bars to relief. *See Beam*, 501 U.S. at 544, *Reynoldsville*, 514 U.S. at 759.

As the Court explained in *Reynoldsville Casket*:

> "Suppose a State collects taxes under a taxing statute that this Court later holds unconstitutional. Taxpayers then sue for a refund of the unconstitutionally withheld taxes. Retroactive application of the Court's holding would seem to entitle the taxpayers to a refund of taxes. But what if a pre-existing, separate, independent rule of state law, having nothing to do with retroactivity—a rule containing certain procedural requirements for any refund suit—nonetheless barred the taxpayers' refund suit. *See McKesson Corp. v. Division of Alcoholic Beverages and Tobacco,* 496 U.S. 18, 45 (1990); *Reich v. Collins*, 513 U.S. 106, 111 (1994). Depending on whether or not this independent rule satisfied other provisions of the Constitution, it could independently bar the taxpayers' refund claim. *See McKesson, supra*, at 45." 514 U.S. at 756.

Here, there is a "pre-existing, separate, independent" rule of law that bars petitioners' claims for retroactive relief. As the Court of Appeals held, there is no state administrative process for awarding retroactive rate increases where the regulation complained of has already been repealed. Otherwise, providers could come in years after they have provided services and received payment and complain that they would have liked to receive a higher rate. For a program

like Medicaid which is funded through annual appropriations from the state legislature, "[s]uch a policy would confound the budgetary process of state government." 11 S.W.3d at 781.

To the extent that petitioners were treated differently by the state courts, it is because they acted differently. Petitioners accepted Medicaid payments for the six years that the payment cap on psychiatric services was in existence without ever challenging the validity of the regulation as Great Plains hospital did. Nor did they ever file a rate appeal within 30 days of being informed of their Medicaid rates, as did Trinity Lutheran and Alexian Brothers hospitals. The Court of Appeals' determination that the petitioners' claims were untimely is purely a question of state law, and nothing in the *Beam* case requires the Missouri state courts to ignore this jurisdictional bar to their complaint.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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